Difficulties providing a sufficient level of care:

Deep dive following the State of Medical Education and Practice (SoMEP) Barometer survey 2025

Prepared by IFF Research for the General Medical Council

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Snapshot summary

This report presents findings from qualitative research commissioned by the GMC to explore, in greater depth, the 2025 SoMEP Barometer survey results on doctors' reported difficulties providing a sufficient level of care to patients. Findings presented in this report are generated from in-depth interviews with 40 doctors practising in the UK. While these qualitative findings are not statistically generalisable, they offer depth, nuance and rich insight into doctors' experience which is difficult to capture through quantitative data.

Providing a sufficient level of care remains a significant challenge for many UK doctors.

In 2025, **two in five doctors (41%) reported finding it difficult to provide patients with the sufficient level of care they need at least once a week**, consistent with previous years. Survey data indicated that these difficulties are most acute among GPs, younger doctors, and those working solely in the NHS, and are closely linked to high workloads, inadequate staffing, and increasing administrative demands.

Doctors' perceptions of 'finding it difficult to provide a sufficient level of care' indicated that this rarely means professional standards or patient safety have been compromised.

Doctors consistently described "sufficient care" as delivering care that is:

Timely: delivering all necessary interventions within appropriate clinical timeframes, avoiding unnecessary delays in diagnosis or treatment.

Patient-centred: understood as listening attentively, respecting individual concerns, and tailoring care to each patient's unique circumstances, ensuring they feel heard, safe and supported.

Whole-patient focused: addressing not just medical symptoms, but also patients' emotional, social, and lifestyle needs, ultimately ensuring all dimensions of need are met – even those the patient may not explicitly articulate.

Throughout this report, whenever timely care, patient-centred care, or whole-patient care is mentioned, this refers to the definitions provided above, as expressed by the doctors we interviewed.

Doctors explained how **professional standards and clinical guidance** were important benchmarks for determining whether they had provided a sufficient level of care but, for some, providing a sufficient care meant extending beyond the fulfilment of minimum safety and professional standards. Doctors commonly considered whether care had been provided according to their own, **personal values and benchmarks**. For example, the 'friends and family test', aiming to deliver care they would want for their own loved ones. Sufficient care is thus defined by empathy, responsiveness, and the ability to treat the whole person, not just the presenting condition.

Alongside systemic factors – which presented a range of barriers to providing the care doctors strived for - many doctors explained that **the "difficulty" in providing a sufficient level of care related to**

the cumulative emotional strain of being faced with situations where they are unable to offer the standard of care they would like. This has led to feelings of frustration, guilt, and professional dissatisfaction.

Systemic constraints force doctors to make difficult trade-offs which compromise their ability to deliver care to the standard they would like.

The most prominent barriers noted by doctors related to **sustained workload pressures, limited staffing capacity, rising administrative demands, and organisational processes** that felt complex or inflexible. Doctors often described these challenges as made more difficult by technology that is unreliable in day-to-day practice, constraints on essential, and management approaches that do not always feel responsive or supportive.

Conversely, doctors reported that they were better able to provide sufficient levels of care when working within **supportive, well-coordinated teams, with clear managerial guidance, dependable technology, and a degree of autonomy** in planning and prioritising their workload. When doctors have access to adequate resources, collaborative colleagues, and flexible organisational systems, they are better able to deliver timely, whole-patient, and patient-centred care that meets their professional standards.

Subgroup differences were evident across roles, settings, and backgrounds.

- GPs placed greater emphasis on continuity and whole-patient support when defining sufficient level care compared to doctors in secondary care settings. Doctors in secondary care more typically defined sufficient care in terms of technical standards and guideline adherence.
- In the survey, doctors working in primary care more frequently reported difficulty providing sufficient care and more likely to cite a number of barriers to providing patient care. In interviews, GPs were more likely to highlight the challenges of short appointments and fragmented services. In contrast, secondary care clinicians described more autonomy and support, with barriers centring on resource constraints and system inefficiencies.
- Enablers of providing sufficient care also varied. In primary care, autonomy and strong patient relationships defined by open communication and patient-doctor trust were key. Comparatively, doctors working in secondary care placed particular value on efficient processes and multidisciplinary teamwork.
- In interviews, doctors earlier in their careers identified less control over workload as a challenge which had a knock-on impact to patient care. Meanwhile, more experienced doctors felt they had more autonomy in delivering patient care but sometimes faced systemic barriers when doing so.

Difficulties in providing sufficient care have important implications for patient experience and system performance.

While doctors emphasised that **fundamental patient safety is rarely compromised**, challenges within the system mean patients are more likely to experience delays, fragmented care, and reduced continuity, especially for doctors working in primary care. Doctors have witnessed **emotional impacts on patients** including frustration, anxiety, and a sense of not being heard, which can undermine trust in the healthcare system and impact the patient-doctor relationship. Doctors stated that system pressures (such as sustained workload intensity, short appointments, limited access to

secondary services and increasing patient complexity) often force them to focus on immediate clinical needs at the expense of addressing wider symptoms and contextual factors/issues or preventive care. Primary care doctors also noted that long waiting lists and referral delays can **sometimes lead to patients returning with repeated or progressed symptom presentations**. This, in turn, places further pressure on services.

Persistently high workloads, ongoing system challenges, and the repeated inability to deliver the standard of care they aspire to has had an impact on many doctors' wellbeing and prompted some to consider leaving UK medical practice.

Many doctors described a **sense of fulfilment and professional pride when they are able to deliver the standard of care they aspire to**. Conversely, systemic pressures and high workloads prevent doctors from meeting their own standards. These pressures can undermine confidence in clinical decision-making, particularly when time constraints force doctors to make rapid judgements or limit opportunities for reflection and learning. Many doctors reported resulting frustration, emotional strain, burnout and a decline in job satisfaction.

For some doctors, this has **caused them to plan early retirement, seek opportunities abroad, or transition out of clinical roles** altogether, as a way to protect their wellbeing and professional fulfilment.

1. Introduction

Background and objectives

The General Medical Council (GMC) commissioned IFF Research to conduct qualitative research to build on the questions in the 'State of Medical Education and Practice in the UK' (SoMEP) Barometer survey 2025. The SoMEP Barometer survey is an annual online survey exploring how doctors' experiences of practising in the UK are changing over time.

The aim of this qualitative research was to dive deeper into the results of the Barometer survey relating to self-reported difficulty in providing a 'sufficient' level of care to patients. We explored in depth what doctors mean when they say they experience difficulty providing a sufficient level of care, what factors make providing sufficient care easier or harder, and the impact that difficulties providing sufficient care has on doctors, patients and working relationships.

Research objectives

The research was designed to better understand:

- How doctors define 'providing a sufficient level of care';
- What it looks like when doctors find it difficult to do this;
- What factors contribute to doctors' feeling able or unable to provide sufficient care on a frequent basis;
- What the effects and impacts are of feeling able or unable to provide sufficient care on a frequent basis.

Research approach

In-depth interviews with 40 doctors currently practising in the UK were carried out between 29th October and 9th December 2025. Each interview lasted approximately 45 minutes, and was conducted either via videocall or, less commonly, via telephone.

Interview participants were recruited from among those who completed the 2025 SoMEP Barometer survey. Doctors taking part in the survey were asked if they would be willing to assist in follow-up qualitative research. A purposive sample from those who had opted in were invited to take part in an interview, using the quotas as set out in Tables 1-4 below.

Quotas were put in place to ensure the research included views from doctors with a range of experiences. Just over half of those interviewed had reported in the Barometer survey that they found it difficult to provide sufficient care on at least a weekly basis, with the other half experiencing this less than weekly. Cross-cutting quotas were set to ensure a mix of doctors working in primary care and in secondary care and in different types of roles (doctors in training, LE doctors, SAS doctors, GPs and specialists), as well as doctors experiencing different levels of workload pressures.

Additional demographic quotas were set for UK nation, gender, international medical graduates, ethnicity, age and disability status.

Table 1. Breakdown of interviews by self-described frequency of finding it difficult to provide a sufficient level of care.

Frequency of difficulty	Number of interviewees
At least weekly	21
Less than weekly	19

Table 2. Breakdown of interviews by role.

Role	Number of interviewees
Primary care (total)	**20**
GP Partner	6
Salaried GP	6
Locum GP	3
GP in training	5
Secondary care (total)	**20**
Specialist	9
Locally employed	5
SAS	2
Doctor in training in secondary care	4

Table 3. Breakdown of interviews by workload quadrant.

Quadrant	Number of interviewees
Quadrant 1: 'Struggling'	18
Quadrant 2: 'Managing'	11
Quadrant 3: 'Normalised'	11

In the analysis of the Barometer survey, doctors' relationship with their workload is explored through quadrants, which map working beyond rostered hours against self-described ability to cope.

Table 4. Profile of doctors interviewed by UK nation, Gender, place of Primary Medical qualification (PMQ), ethnicity, age and disability.

Demographic group	Number of interviewees
Nation	
England	27
Northern Ireland	4
Scotland	5
Wales	4
Gender	
Male	19
Female	21
PMQ	
UK	23
European Economic Area (EEA)	6
Outside the UK and EEA	11
Ethnicity	
White	23
Ethnic minority	17
Age	
50+	17
40-49	9
30-39	11
Under 30	3
Disability, long-term illness or health condition	
Yes	10
No	30

Topic guide

The topic guide used for the depth interviews was designed to be open, conversational and guided by the participants' personal experiences. This helped ensure participants were able to convey what they felt were key messages or share examples of situations they felt were most relevant. The questions in the topic guide were designed in collaboration with the GMC.

Each interview began with a brief discussion of the participant's role, the setting they worked in, and their current workload. This was then followed by questions exploring how the participant defined 'sufficient' care, what 'difficulty' providing sufficient care looks like, factors they felt make it easier or harder to provide 'sufficient' care, and the impact that difficulties providing sufficient care has on themselves, their patients and their relationships with their colleagues.

For the full topic guide questions, please refer to the Appendix of this report.

Analysis and reporting

This report outlines the findings from the 40 depth interviews conducted with doctors.

Detailed notes from each interview were entered into a thematically structured analysis framework document, to enable comparison between interviews and easily identify differences or commonalities. After individual immersion in the data, researchers from IFF met in an analysis session to discuss emerging findings and clarify themes. An interim findings session was then held with GMC to further develop the narrative. This involved jointly scrutinising and challenging initial interpretations of the data to ensure the final findings best meet the research objectives.

It is important to note that although this research provides detailed insights into how doctors experience challenges in delivering sufficient patient care, the findings should be interpreted with some care. The study draws on a relatively small and diverse sample of interview participants, meaning the views reported illustrate individual experiences rather than representing all doctors. As with all self-reported accounts, perspectives may be influenced by personal context and may not capture every factor shaping care delivery across different settings. The themes identified reflect patterns commonly described by participants but cannot be used to determine how widespread these experiences are. Quotations are included to illuminate specific issues rather than to imply frequency.

Relevant results from the 2025 Barometer survey are also referenced throughout the report for context; while survey data is used to provide contextual background, the qualitative and quantitative findings serve different purposes and should be read as complementary rather than directly comparable.

2. Context from the SoMEP Barometer survey 2025

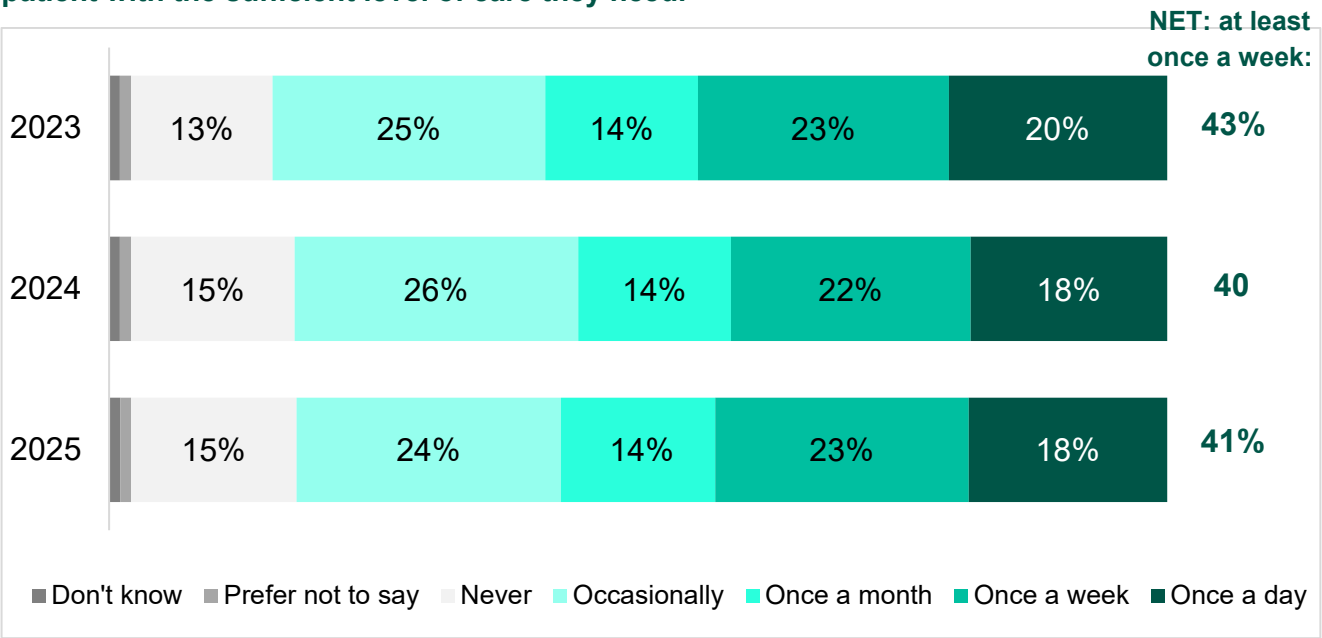
This chapter presents relevant headline findings from the State of Medical Education and Practice (SoMEP) Barometer 2025 survey. This includes the results of survey questions related to difficulty providing a sufficient level of care in the 12 months prior to completing the survey, instances of compromises to patient safety, and barriers to providing patient care. This provides context to better understand the findings from the qualitative interviews, which are discussed in subsequent chapters. Other survey findings are included throughout the report at relevant points.

In this chapter and throughout the report, any differences mentioned between types of respondent in the survey or between different years are always statistically significant (i.e. we can be 95% confident that these are 'real' differences in views between different types of doctor, rather than these apparent differences simply being due to margins of error in the data). Differences which are not statistically significant have not been reported. When we say a specific group of respondents are different to the average, we mean that the group is significantly different to the findings of all other respondents.

Difficulty providing sufficient care

As part of the Barometer survey, doctors were asked to select how frequently, if ever, they 'found it difficult to provide a patient with the sufficient level of care they need' over the 12 months prior to taking part. In 2025, 41% of doctors said they experienced this at least once a week, including 18% who said they experienced this at least once a day. This is consistent with findings from the previous two years of the survey (2023 and 2024).

Figure 1. Chart to show doctors' estimate of how frequently they find it difficult to provide a patient with the sufficient level of care they need.



C1_4. How frequently, if at all, over the last year have you experienced the following? Found it difficult to provide a patient with the sufficient level of care they need. Base: All doctors (4606).

Responses varied by the type of role held: GPs were more likely to say they found it difficult to provide sufficient care at least weekly (60%), whereas SAS, Locally employed and specialist doctors (38%) were less likely to say this (25%, 33% and 38% respectively). Those working only in the NHS

were also more likely to say this (42%), while those working only or mostly in private settings were less likely (18%).

Other groups more likely to say they found it difficult to provide a sufficient level of care at least once a week included doctors aged under 30 (50%), White doctors (48%), doctors who gained their PMQ in the UK (51%), disabled doctors (52%), LGBTQ+ doctors (57%), and doctors working mainly in Scotland (46%) or Wales (47%).

Frequently feeling unable to provide a sufficient level of care was associated with lower satisfaction,[1] being at a higher risk of burnout,[2] and feeling unable to cope with workload.[3]

Witnessing compromised patient safety

Four in ten (39%) doctors had witnessed a situation where they believed patient safety or care was compromised in the past year. This was consistent with survey results from 2024 and 2023. Specialists were particularly likely to report having witnessed a patient's safety or care compromised (44% vs. 39%), while LE and SAS doctors were least likely to (34%) report this.

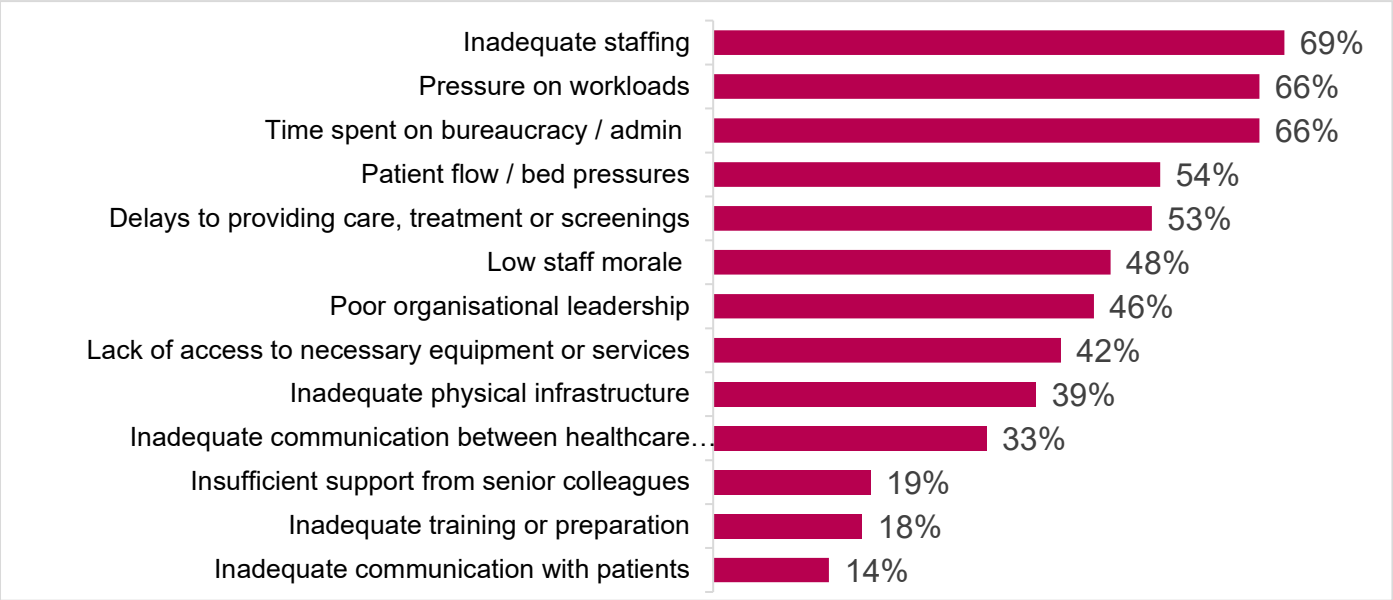
The main reasons for patients' safety or care being compromised was primarily attributed to workloads (63%) or inadequate staffing (62%), followed by delays to providing care, treatment, investigations or screenings (57%).

Barriers to good care

The survey asked doctors to identify the main barriers they have experienced to providing good patient care over the past year. Inadequate staffing (69%) was the most frequently cited barrier in 2025, consistent with past years. This was closely followed by pressure on workloads (66%) and time spent on bureaucracy and admin (66%).

[1] Doctors who were dissatisfied overall were more likely to say they experienced difficulty providing a sufficient level of care at least weekly (62%) than those who were satisfied (27%). Only 17% of those who were 'most' satisfied said they experienced this at least weekly.
[2] Of those who showed 6-7 indicators of burnout ('high risk'), 67% said they found it difficult to provide sufficient care at least weekly. This compared to only 22% of those who showed 0-1 indicators of burnout ('low risk').
[3] Of the 36% of doctors who said they felt unable to cope with their workload at least weekly, over two thirds (68%) said they found it difficult to provide a sufficient level of care at least weekly.

Figure 2. Chart showing doctors' views of the main barriers to patient care.



C9. What would you consider to be the main barriers, if any, to providing good patient care that you have observed or experienced over the last year? Base: All doctors (4606).

Doctors who gained their PMQ in the UK were generally more likely to select each barrier to patient care than doctors who gained their PMQ outside of the UK. The exception to this was inadequate training or preparation, which doctors who gained their PMQ in the EEA were more likely to select (25% vs 18% UK PMQ), and insufficient support from senior colleagues, which was consistent across PMQ areas.

Differences in responses by register group:

- GPs were more likely to report pressure on workloads (78% vs. 66%), time spent on bureaucracy / admin (71% vs. 66%), delays to providing care, treatment or screenings (73% vs. 53%), lack of access to necessary equipment or services (47% vs. 42%) and inadequate communication between healthcare professionals (45% vs. 33%) as barriers to patient care.
- Specialists were more likely to name patient flow or bed pressures (58% vs. 54%), low staff morale (58% vs. 48%), poor organisational leadership (57% vs. 46%) and inadequate physical infrastructure (46% vs. 39%) as barriers to patient care.
- Doctors in training were more likely to select most barriers compared to other register groups, the only exceptions were delays to providing, care, treatment or screenings, low staff morale and poor organisational leadership.
- Locally employed doctors were more likely to report inadequate staffing (74% vs. 69%), patient flow or bed pressure (61% vs. 54%), insufficient support form senior colleagues (28% vs. 19%), and inadequate training or preparation (29% vs. 18%).

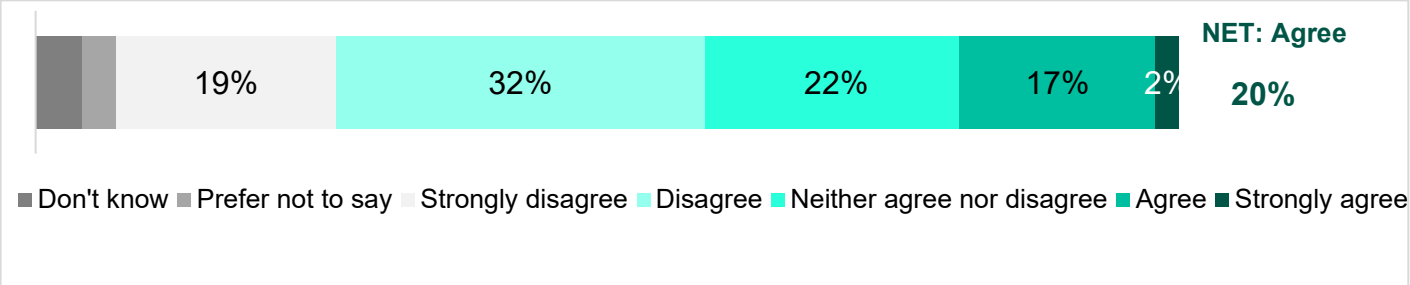
Effective coordination of patient care

Only one in five (20%) doctors agreed that there is effective coordination of patient care between primary and secondary care. Doctors who found it difficult to provide sufficient patient care on a weekly basis (10%) or had witnessed a patient safety compromise (11%) were much less likely to agree with this statement.

GPs (12%), specialists (15%), doctors with a UK PMQ (14%), disabled doctors (16%) and mid-career doctors (17%) were all less likely to agree there is effective coordination of patient care between primary and secondary care. Conversely, SAS doctors (28%), LE doctors (26%) and doctors in training (23% - particularly those in GP training 32%) were more likely to agree, alongside doctors who gained their PMQ outside the UK or EEA (30%), and early career doctors (22%).

Being less likely to agree that there is effective coordination of care was associated with several other negative indicators, such as dissatisfaction (9%) high risk of burnout (10%) and being in the 'struggling' workload quadrant (13%). While doctors who felt part of a supportive team were more likely to agree (22%).

Figure 3. Agreement with the statement, 'In my experience, there is effective coordination of patient care between primary and secondary care'.



D3_X: To what extent do you agree with the following statements? Base: All doctors (4606).

3. What does 'difficulty providing a sufficient level of care' look like?

This chapter examines how the doctors interviewed define a sufficient level of care and how they judge whether this standard is met in practice. It explores the factors these doctors draw on when making these judgements and compares perspectives across those who are working in primary and secondary care settings.

Defining a 'sufficient' level of care

Doctors tended to define sufficient care as care that is **delivered in a timely manner, addresses patients' needs comprehensively, and recognises their health and life holistically** rather than as isolated conditions. For some doctors, providing a sufficient level of care meant extending beyond the fulfilment of minimum safety and professional standards which related to these factors.

Timeliness was repeatedly emphasised as a core component of sufficient care, with doctors noting that all necessary interventions should be provided within an appropriate timeframe; this was often interpreted as the timeframe specified in clinical guidance for a given intervention. This included avoiding delays in diagnosis, treatment, and referral processes. When care is delayed, patients often re-present with unresolved or worsening problems, which can negatively affect health outcomes. Doctors felt delays can also undermine patient trust in healthcare services and a sense of continuity of care.

> *"[Sufficient care] means I can do everything necessary in the timeframe that it should happen … in my job I should be able to do a caesarean section in the time stated by the Royal College's Obstetricians & Gynaecologists guidelines, and I should be able to provide the care they need in that time. The Royal Colleges look at what is the best way of practice, and some is evidence based and some experience based … we have to and want to adhere to [that]."*
>
> **Specialist, Secondary care**

> *"The first thing that comes to mind is care that's 'timely care', and that it's provided as and when the patient needs it, and that there's no unnecessary delays with that."*
>
> **Doctor in training, Secondary care**

Patient-centredness also emerged as a fundamental dimension of sufficient care. Doctors highlighted the importance of listening attentively to patients, understanding their concerns, and ensuring that issues were addressed effectively so that patients do not need to return later for the same problem. In their accounts, sufficient care involved making patients feel heard and respected, and tailoring care to individual circumstances rather than relying on a uniform approach. These practices were described by participants as central to strengthening the doctor-patient relationship and enhancing patient satisfaction.

> *"If they come with a certain problem - for instance a headache - it often has multifactional layers... Not just clinical, but what matters to the patient that takes 75% of the time."*

Specialist, Secondary care

Doctors emphasised that **providing a sufficient level of care requires a 'holistic' approach that considers patients as a whole** (referred to as 'whole-patient care' within this report). Beyond clinical interventions, sufficient care encompassed attention to emotional, social, and lifestyle factors that influence health. Understanding these factors often required spending adequate time with patients, offering reassurance and support, and recognising patients as individuals with needs that extend beyond their immediate medical condition. Doctors stressed that health outcomes are shaped not only by the management of symptoms, but also by emotional wellbeing and social context.

Doctors interviewed across different settings shared broadly similar views on what whole-patient care meant within their contexts. However, when speaking about whole-patient care, GPs more commonly referred to not having enough time to address everything, and needing to focus on the most urgent issues presented. Some GPs also included follow-up and ongoing support in their definition of whole-patient care. Secondary care doctors typically spoke about seeking to support patients' emotional needs and worries and not focusing solely on the body part or problem their work focused on.

> *"It is not just treating their medical symptoms, it should be providing care like comfort and spending time and talking with them to make sure they are fine and particularly not in pain. Medicine is a holistic approach, treating emotional symptoms as well."*
>
> **Locally employed doctor, Secondary care**

> *"We used to do all of this as good practice in the good old days. Sometimes people feel left out because nobody has contacted them after a family member has died or they have anxiety or unhappiness about their care … it is all lost now … there is no time with a lot of patient appointments and constant demand from patients for appointments."*
>
> **Salaried GP, Primary care**

At its core, sufficient care was understood by most doctors as care that is delivered on time, addresses the whole patient, and balances technical competence with empathy, responsiveness, and professional judgement.

In addition to these considerations, doctors described a range of clinically practical decision-making processes underpinning everyday care. These included using national guidance as a baseline for safe practice, actively triaging and prioritising patient concerns based on risks, and focusing on ruling out serious causes when time or resources were limited. While sufficient care is guided by clinical priorities, doctors' decisions were also influenced by practical realities such as staffing, availability of procedures, and delays to secondary care. They adapted their plans to navigate these challenges while still aiming to provide safe and effective care.

> *"You're always risk assessing: What is the risk here? What do I need to do? What can I do that will be timely?"*
>
> **GP Partner, Primary care**

How doctors judge if they have achieved sufficient care

Doctors across all settings commonly described assessing what is a sufficient level of care by asking whether they have lived up to their **personal values**. Across interviews, some doctors referred to the **'friends and family test' as a personal benchmark**, using it to judge the quality of care they provide by asking themselves whether the care they deliver would be acceptable if the patient were a close family member or friend. Often, this meant going above and beyond the requirements set by standards. This approach emphasises empathy and reflects the value placed on ensuring that clinical decisions align with their own standards of compassion and thoroughness.

> *"I think it is not just a bit of standard of care, there's the personal standard of care that you aspire to give each patient, in other words, the kind of family and friends test that, you know, you put to yourself, would you want your relative to be treated this way?"*
>
> **Specialist, Secondary care**

If they fall short of their own standards, they consider the care insufficient - even when it still meets safety and regulatory minimums.

That said, doctors did describe drawing on **professional standards and clinical guidance** as an important benchmark for determining whether they had provided a sufficient level of care. Many referred to the expectations set out in national guidelines, Royal College standards and local clinical protocols, using these as reference points for what timely and appropriate care should look like in their specialty. For example, several secondary care doctors defined sufficient care as meeting clinical protocols, conducting timely diagnostics, and completing interventions within recommended timeframes, which were frequently framed as key markers.

Although these **professional standards were often seen as the baseline for safe and effective care**, doctors emphasised that system pressures sometimes prevented them from meeting them as consistently as they would like. In these situations, they still aimed to uphold the core principles of good medical practice, even if aspects of care - such as timeliness or completeness - were compromised by factors beyond their control.

Beyond these benchmarks for care doctors applied to their practice, doctors used indicators which largely reflected their definition of sufficient care. For example:

- ✓ Did the patient receive the care they needed, when they needed it?
- ✓ Was anything clinically important delayed?
- ✓ Is a follow-up plan in place?
- ✓ Was anything left unresolved?
- ✓ Are referrals / investigations moving?
- ✓ How likely is the patient to return with the same issue?

Defining 'difficulty' providing a sufficient level of care

Doctors were clear in emphasising that, in their view, 'finding it difficult to provide sufficient care' **did not necessarily correspond to failing to meet professional standards or putting patients at risk**. Rather, they were falling short of the care standards they set for themselves. Some doctors,

particularly GPs, referred to the **'friends and family test' as a personal benchmark** in their decision-making. This approach emphasises empathy and ensures that clinical decisions align with their own standards of compassion and thoroughness.

Difficulty in providing sufficient care was rarely attributed to a lack of knowledge or motivation. While some doctors – particularly those earlier in their careers or new to a setting – described learning curves around system processes or decision-making, these were typically perceived as secondary and/or temporary challenges, as their impact was often easily mitigated through peer support. Challenges around learning curves and system processes were described as impacting care, but mainly by slowing things down, and at times, reducing the time available for patients, rather than creating immediate safety risks or significantly compromising the care delivered.

Instead, doctors described **a range of systemic and contextual constraints that limited what they were able to provide in practice.** Navigating a system where they constantly faced challenges, and being left to feel like they could have provided *better* care often resulted in a sense of emotional strain. **Doctors often attributed the notion of 'difficulty' to this emotional strain.**

Participants reported that being **unable to give patients the time and attention they felt was warranted**, whether due to workload pressures or organisational policies, led to **feelings of professional dissatisfaction and moral discomfort**. For many doctors, this was not simply a matter of efficiency or workload management but related to preserving the human connection they viewed as central to delivering high quality care.

> *"I am watching people around me refuse to have any kind of relationship with their patients because of the pressures of the work… These things tell me that other people are not developing rapport with their patients… the only thing that keeps me going is rapport."*
>
> **Locally employed doctor, Secondary care**

Doctors often need to address multiple issues within a single, relatively short appointment, often limiting the depth of assessment and delaying timely care for some concerns. **Time pressures** have forced doctors to prioritise immediate clinical concerns over broader patient needs. This limits opportunities for conversations about lifestyle, emotional wellbeing, or preventative care, and for providing reassurance. This often created a tension between what doctors felt was necessary for sufficient care and what could realistically be delivered within existing constraints.

Doctors explained how, **in everyday clinical settings, delivering what doctors consider to be sufficient care often involved making difficult trade-offs.** Doctors described how this necessity to prioritise efficiency over depth can feel misaligned with their professional values and aspirations.

> *"Doctors have a pretty high standard, such that if you don't think you've done everything you can, you internalise it and you can feel guilty, like maybe I didn't provide a sufficient level of care for a particular patient."*
>
> **Locally employed doctor, Secondary care**

Limitations in resources, system capacity and service availability were also seen as a significant factor in how doctors defined 'difficulties' in providing sufficient care. Doctors frequently described these difficulties as arising in situations where they were required to deliver patient care while managing insufficient staffing levels, restricted access to specialist services, and **patients often facing delays and cancellations**. These delays and cancellations in secondary care often left

patients without timely specialist input, again, affecting both primary and secondary care and again resulting in them returning to general practice with unresolved or ongoing issues and an experience of fragmented and repetitive episodes of care. For example, a patient may wait up to two years for joint surgery, endure months-long delays for diagnostic scans, or experience urgent referrals that take hours to arrange. These gaps increased pressure on GP services and contributed to fragmented care, with responsibility for management frequently shifting back to primary care without additional support. While this issue was most strongly and consistently articulated by GPs, secondary care doctors also highlighted how delays and cancellations as a result of system capacity constraints limited their ability to provide prompt and continuous care.

> *"Certain conditions that have malignant potential can become cancerous if you leave them and, you know, guidelines say I should see them every three months. So I would dutifully book them a three month appointment but who knows when I'd see them again, it could be years."*
>
> **Specialist, Secondary care**

Doctors also pointed to **organisational and procedural constraints**, including growing administrative demands and repeated referral rejection – particularly in mental health – which limited their ability to progress care even when clinical need was identified. These pressures were described as contributing to a sense that care becomes fragmented, and that important aspects of patient care are left unaddressed.

> *"A satisfied patient who does not need to come back for the same problem."*
>
> **Salaried GP, Primary care**

Differences between primary and secondary care in defining and delivering sufficient care

In practice, there are structural and operational differences between primary and secondary care. These differences were sometimes reflected in how doctors across different settings talked about delivering sufficient care. For example, doctors in primary and secondary care placed emphasis on different elements of the patient or doctor experience when defining sufficient care, or highlighted difficulties which were more relevant to their setting.

When defining what sufficient care looks like, doctors[4] interviewed who were working in primary care placed greater emphasis on continuity, accessibility and the ability to provide whole-patient care. . For these doctors, timely access to appointments and continuity of care were frequently highlighted as central, allowing patients to receive follow-ups and support for both medical and broader emotional or social needs. For GPs, sufficiency included being able to coordinate care and act as the patient's anchor in a complex system, not just deliver care within the consultation.

Systemic barriers that these GPs reported facing, which prevent them from delivering optimal care, include long waiting lists for referrals, fragmented services, and administrative burdens that undermine continuity. Fragmentation was often described through limited follow-up access and lack of continuity, with patients frequently seeing multiple GPs for the same issue, which could lead to confusion, repeated explanations, and delays in appropriate treatment.

[4] This included GPs, including partners, salaried GPs, locum GPs and GPs in training.

Administrative burdens, including complex referral paperwork, repeated documentation, managing multiple IT systems, and time spent chasing test results or responses from external services, exacerbated this fragmentation. GPs reported that these tasks increasingly interfered with consultation time, reducing capacity for follow-up and whole-patient care.

> *"We get upset because we feel we are not giving the best service and just firefighting all the time and not giving the best holistic care… patients sometimes come back to us more often because we have not had time to deal with then properly initially."*
>
> **Salaried GP, Primary care**

GPs were also particularly likely to note the impact on the doctor-patient relationship, reporting that a significant portion of their time is spent explaining some limitations of the system rather than focusing on patient care. Time pressures were frequently described as further limiting continuous and whole-patient care. Some GPs described managing the tension between short appointments and whole-patient care by prioritising one issue per visit and arranging follow-ups for broader concerns, though many noted that time pressures still made comprehensive care difficult to sustain. Although GPs aim to address multiple health issues, provide emotional support and conduct thorough follow-ups, short appointment times and growing administrative responsibilities make this increasingly difficult.

> *"If you are massively behind on time, you are saying to people 'I can only deal with two things in this consultation', which leaves a bad taste in the mouth of people with multi-morbidities and it has taken them four weeks to get an appointment and they have got a lot to talk about and not given the opportunity to do so."*
>
> **Locum GP, Primary care**

Ultimately, many GPs interviewed reported measuring sufficient care not only by clinical outcomes but also through the patient experience, striving to maintain continuity, foster trust, and provide whole-patient care, while recognising that systemic and time constraints can undermine the doctor-patient relationship. Some GPs describe the inability to personally follow up with certain patients as a significant frustration, noting that this can limit the quality and continuity of care they provide. For many, continuity of care is central to their practice, yet is increasingly difficult to maintain due to restrictive appointment systems and new policies now in place.

> *"I like to be able to appropriately follow up a patient and in a lot of practices you don't have the capacity to do that. A lot of practices work on the premise of wait four weeks for an elective appointment or ring on the day and get an on-call appointment – nowhere in between… [if] you want to follow someone up in a week or fortnight, it is very difficult to do that, and put into the hands of the patient to ring up the surgery at eight in the morning and wait an aeon on the phone for the receptionist to answer them… it's a big problem and it never used to be like this."*
>
> **Locum GP, Primary care**

In comparison, doctors in secondary care more typically defined sufficient care in terms of technical standards and guideline adherence. Resource constraints such as limited operating room availability, shortages of specialist nurses, and delays in scans or other tests are key

frustrations that impede their ability to meet these standards. That stated, secondary care definitions of sufficiency weren't only technical; these doctors also sought to provide compassionate and emotional support, but these factors were **secondary to meeting clinical standards** because of the nature of their roles.

Secondary care doctors interviewed often described prioritising safety and risk management. Sufficient care was frequently framed around avoiding harm and maintaining minimum safety thresholds, even when emotional aspects are compromised. While specialists acknowledged the importance of broader patient needs, most placed more focus on technical adequacy and system efficiency over social or emotional support. This divergence reflects differences in the type of care being provided and typical patient relationships in secondary care; GPs depend on sustained engagement and adherence, where relational and patient-centred factors are critical, whereas secondary care tends to involve time-limited, technical interventions, with success defined more procedurally.

> *"How many patients should be treated within 62 days of referral and being able to, you know, to meet these targets is a fairly good indicator as to whether I'm providing adequate care or not."*
>
> **Specialist, Secondary care**

Overall, the interviews suggest that primary care doctors **tended to frame sufficient care through continuity, accessibility, and patient well-being, while those working in secondary care more often emphasised technical precision, guideline adherence, and timely preventions, while also demonstrating patient-centred approaches.** These different emphases reflect the distinct roles of each setting, but they also highlight the importance of improved coordination to prevent fragmented care and ensure that patients' medical and emotional needs are both met.

> *"There's a lack of communication between primary and secondary care… discharge letters even after a week are not sent to us."*
>
> **GP in training, Primary care**

4. Enablers and barriers to providing a sufficient level of care

This chapter explores doctors' experiences and perspectives on what helps or makes it harder for them to provide a sufficient level of care. Within the interviews, doctors were asked both what factors supported them to be able to consistently provide a sufficient level of care and what factors made this harder. After interviewees gave their unprompted responses, those who had not spontaneously mentioned the intensity of clinical workload, the complexity of the system and/or the complexity of patient needs were asked about these issues specifically ('prompted responses').

Doctors' descriptions of what helps and makes it harder to provide sufficient tended to cluster around the following fundamental conditions:

- Sufficient time to carry out their role to the personal standard.
- Ability to easily secure and coordinate onward care from other medical professionals with a different role in a patient's care (e.g. timely referrals to specialists).
- Access to the physical resources and support services needed to carry out their role.
- Access to the necessary information to make informed decisions, including relevant patient records or data, advice from others when needed, and the opportunity to develop their own professional skills or knowledge.
- The permission or authority to carry out the task they feel are necessary to their role.

Doctors tended to report difficulties providing sufficient care where these conditions were eroded or not met (or doctors perceived them to be so).

Specific factors that influenced whether these conditions were met are outlined in the section below, though it should be noted that these factors were often closely interlinked.

Factors affecting doctors' ability to provide sufficient care

Workloads

In both the qualitative research and the Barometer survey, **high intensity of workloads** was felt to be an important barrier to providing good care, with two thirds (66%) of survey respondents citing pressure on workloads as one of the main barriers to patient care.

In interviews, doctors explained how high workloads **reduced the time they could directly spend on each patient's care**. This was felt to increase the risk of **making mistakes or missing important details** when feeling rushed, as well as compromising doctors' ability to provide the **emotional support** that many saw as a vital part of 'sufficient' care, especially in primary care. Some also described how **working late or missing breaks** (sometimes as an expected part of their schedule) made them more tired, which made it harder to do their job well.

"You may not be as fresh or as empathetic when you're exhausted. When your cup is starting to get empty it's difficult to pour from it."

GP Partner, Primary care

Alongside these immediate risks to providing sufficient care, doctors were **concerned about sustaining their ability to provide good care in the long term** if workloads remain consistently high. Doctors in training were concerned about their **ability to grow their skills and progress** as a doctor, because they feel they don't have any time for learning or reflecting on complex cases during their working day. Doctors were also concerned that **chronic stress or burnout** could impact their ability to continue to provide good care if workloads remained intense, with some considering leaving the profession as a result.

Some doctors who felt they had more **autonomy** over how they arranged their work described how this helped them to manage their workload and mitigate resulting difficulties, even if their workload was still intense. Swapping to locum roles or dropping to part-time gave some doctors greater control over when they worked and enabled them to work in a way that fit them best, meaning they felt more well-rested in the hours they were working. Others were able to optimally arrange their schedule within their working day to reduce the pressure.

Some GP partners gave examples of how they had used their greater level of autonomy to make positive changes to how their practice runs to reduce the intensity of workloads, such as extending the length of appointments or ensuring that their staff take breaks.

"There's something very helpful to me about being a partner, because you can make change within a practice, which we're lucky to be able to do. Because I think if you work in secondary care, making change is very, very difficult."

GP Partner, Primary care

Adequate staffing

Doctors felt inadequate **staffing was a key contributor** to workload-related issues, and therefore to consistently providing sufficient care – inadequate staffing the most commonly reported barrier to good patient care in the Barometer survey (69% selecting as a main barrier). In interviews, doctors said they were sometimes expected to squeeze in extra patients or tasks to provide cover, or work in roles outside their typical responsibilities. Some doctors working in hospitals described struggling to manage patients across multiple wards of a hospital due to a lack of staff, as they could not be present in all places if a patient deteriorates.

"You have a patent there and another a ten-minute walk away, and another five minutes away, round a corner and through two doors. What if one deteriorates while I am at bedside with another one? That person is my responsibility, and my name is attached to them on the board."

Locally employed doctor, Secondary care

Doctors reported that healthcare teams often lacked the right skill mix, with strong specialty expertise not always covering gaps in other areas of care. In practice, the "right skill mix" was described as requiring both a multidisciplinary combination of healthcare professionals – such as nurses or physiotherapists – and the presence of appropriately trained specialist staff within teams. For example, when nurses or healthcare assistants were not able to take observations or prepare patients for procedures, diagnosis and treatment may be delayed or require more time from doctors.

"If they've got tummy pain or similar, it helps if they've had observations. The thinner on the ground the nurses are and healthcare support workers are, the less likely the patient is going to come in front of me nicely packaged up and ready for me to make a decision, and that just adds delay and adds frustration."

Locally employed doctor, Secondary care

This misbalance of skills within teams made it harder to provide comprehensive, coordinated care, increased workload and pressure on staff, and sometimes required doctors to step in to manage tasks outside their usual responsibilities.

"Timely respiratory input on a ward appropriate with the appropriate skill mix and staffing levels, which we do not have. This would also include physio therapists, speech and language therapists, and dietitians."

Specialist, Secondary care

However, doctors also gave examples of services that had made good and appropriate use of other types of staff, such as pharmacists or advanced nurse practitioners, to free up doctors' time. This included embedding additional types of clinicians, such as phlebotomists, into primary care services to improve efficiency.

"We have our team here, they are very, very helpful. Like we've got the phlebotomist and you can ask them to book for blood. The phlebotomist will quickly bring them, do the blood, and in one or two weeks (get the results)."

Doctor in training, Primary care

Even without gaps in a rota, some doctors described how operating only just above the 'sufficient' level of staff meant that managers or senior doctors had to **invest significant energy in contingency planning**, to ensure services remain available in the event of unexpected absences such as staff sickness.

Doctors often associated inadequate staffing with underfunding and closely linked this with high workloads and wider capacity issues across the NHS.

Wider NHS capacity

Long waiting lists and **gaps in services** meant doctors, especially those in primary care, **were not always able to secure patients** the onward treatment they need in a timely way. Some GPs felt that in their local areas some **routine referrals may never be seen**. This means some patients may miss out on care entirely, while others may have to wait a very long time.

Doctors described **reduced local operating capacity** – such as theatres without adequate staff, loss of specialist inpatient units or lack of services like physiotherapy and diagnostic scans. Several doctors explained that when local facilities are already at or over capacity, patients are often unable to receive treatment close to home. This leads to longer waiting times and forces patients to travel sometimes long distance for care. Both primary and secondary care doctors raised this issue, but from different perspectives. Secondary care doctors tended to describe reduced theatre time, staffing gaps or infrastructure failures that meant patients could no longer receive treatment locally and had to be transferred elsewhere, while primary care doctors and those working in A&E most often experienced the downstream effects, with patients returning repeatedly with unresolved issues or needing to travel further for diagnostics or treatment. Doctors explained that these delays not only

make care slower, which is an important part of sufficient care, but also cause more stress for patients and their families, and make follow-up care harder. For doctors, these delays add extra pressure, because they have to manage patients' expectations and deal with practical challenges, which makes it harder to provide complete, patient-focused care.

> *"The easiest way is to describe what's changed… It used to be that 90% of patients needing retinal surgery would get operations locally. Now 30% get acute care locally and we send the rest to London, because we don't have access to emergency surgery because of cancer patients."*
>
> **Specialist, Secondary care**

In these instances, patients are trying to get support in coping with their symptoms or pain, though often doctors were not able to treat the issue in these settings.

> *"There are things we can't manage in primary care, but secondary care are overwhelmed, and they're not able to then support [the patient] in secondary care. Which is fine for [the doctors in secondary care], because the patient isn't coming back and forth to them for appointments trying to work out what's going on, and saying, 'Well, I'm still in pain, what's happening?'. Whereas in primary care, we have the patient coming back and forth… and I can't find a way to fix [the patient's] problem, which is really frustrating. We feel like we're failing patients like that.'*
>
> **Doctor in training, Primary care**

This puts **extra pressure on GPs** to manage patients while they wait for specialist care, which can be especially challenging when the health concern is complex and/or requires specialist knowledge to manage well.

> *"Because patients have such long waits to get secondary care, it means we're doing a lot more managing of patients with advice and care, who really should be under a consultant… It takes a year to get an appointment with a cardiologist."*
>
> **Salaried GP, Primary care**

Doctors working in emergency departments described how being forced to assess or treat patients in corridors due to a lack of available beds was incompatible with the basic privacy and dignity they considered to be part of sufficient care.

> *"You have to take a history from them where there is no privacy [in the corridor]. You have to expose their abdomen where there's no privacy – anyone could be walking past. Every time I meet one of these people, I have to say, 'I am sorry that I am reviewing you on the corridor – I have no control over this. I have to examine you because that's my job, and if I don't examine you thoroughly, I might misdiagnose you and cause you harm'… It's horrific."*
>
> **Locally employed doctor, Secondary care**

Conversely, a few doctors gave examples of services where there was good capacity, and the positive impact that could have. For example, being able to access advice quickly, or being able to secure care for their patients more quickly than they would be able to provide themselves.

"The frailty service is amazing ...a massively positive impact. If we have a patient who needs a visit, we phone the frailty service.....It's absolutely worth its weight in gold!"

GP Partner, Primary care

Capacity issues were linked by doctors to workload issues and inadequate staffing, as well as contributing to increasing patient complexity.

Administrative expectations

Although doctors recognised the necessity of thorough documentation, **high volume of administrative tasks** with little dedicated admin time was also felt to be driving this workload intensity and leading to doctors having less time to spend directly on patient care. This corroborates the findings of the Barometer survey, where two thirds (66%) of respondents cited time spent on bureaucracy / admin as one of the main barriers to patient care.

This was particularly frustrating to doctors when they felt the admin tasks they were expected to complete were **inefficient or unnecessary,** such as adding clinician-facing comments to normal test results on the records system or recording conversations verbatim rather than as summaries**.** Expectations to complete patient-related admin within the time allotted for that patient's appointment particularly affected GPs, who felt this reduced the time they could spend talking to the patient in that appointment. Others were frustrated by the increase in time needed for administrative tasks due to difficulties with poor technology and limited communication options (see 'Unreliable and/or inefficient technology' below).

"We don't have enough time for the [admin]. The workload generally seems to be ok, but the amount of time that we get for admin doesn't look to be sufficient."

Salaried GP, Primary care

Where support with administrative tasks was available, doctors emphasised the positive impact this could have by reducing the burden on their workload.

Time spent on administrative tasks was felt to feed into issues around high workloads but was in turn exacerbated by challenges with information and communication systems.

Efficiency and reliability of information and communication systems

Doctors rely on IT systems to efficiently access patient information and communicate information with others involved in a patient's care.

However, some doctors reported that the **patient records systems they used were poorly coordinated and were not always compatible with other systems** they needed to use. This meant doctors were not always able to access important information about a patient's history, particularly for interactions or treatments in other healthcare settings, or to share documents, test results or recent patient observations with others involved in a patient's care. As well as wasting doctors' time finding workaround solutions, these issues could result in **delays or unnecessary difficulties in providing the correct diagnosis or treatment plan.**

Some doctors **experienced difficulties communicating efficiently with their internal or external colleagues** due to limited, outdated or unreliable communication methods. This included having to rely on paper postal systems for letters to communicate externally, particularly between primary and

secondary care or when sending prescriptions or struggling to successfully contact internal colleagues due to a reliance on landlines without answering machines or very limited storage of call-back numbers on bleeps. Doctors said these challenges made it harder to effectively co-ordinate with other teams or services, caused delays to patients receiving care, and reduced the amount of time doctors could spend on direct patient care. These communication challenges related to technology were felt to be particularly acute when communicating between primary and secondary care, as technology systems were often incompatible.

> *"It's archaic, some of the ways we communicate between each other as health professionals. There might be a bleep or there might be a phone number. But why can't it just be that you say this message needs to go to the on-call general surgical doctor, and it routes its way to the right place, rather than you phoning a switchboard?"*
>
> **Doctor in training, Secondary care**

Some doctors reported that **available computer equipment is outdated or extremely slow**, making it time-consuming or even impossible to load the software or information they needed. This wasted doctors' time and sometimes made it difficult for them to access the information they needed to provide patients with care.

> *"We've put our foot down and said we cannot see more patients in clinic because it takes us so long to search through these poor computer systems. So it affects our productivity."*
>
> **Specialist, Secondary care**

Even where technology is working as planned, it was sometimes felt to come with drawbacks. Some doctors – particularly in primary care – reported that technology has reduced in-person visits, which they were concerned could negatively impact patient safety or their ability to build rapport.

> *The impersonal nature of digital 'tasks' means you're not actually seeing the patient and examining them… you end up doing far fewer face-to-face consultations, which doesn't feel safe or holistic."*
>
> **Salaried GP, Primary Care**

However, a few doctors mentioned instances where information and communication systems were working well, and enabled doctors to more consistently provide sufficient care. One described how IT systems becoming more co-ordinated across Northern Ireland had supported information-sharing and enabled more joined-up care to take place. Similarly, some thought having a wider range of methods for interacting with patients, such as text communication or video/telephone appointments, enabled them to see patients they might otherwise struggle to see, and reduced the risk of patients missing information.

Complexity of patient needs

Some doctors feel that the **complexity of patient needs has been increasing,** and that this is contributing to difficulties providing all patients with a sufficient level of care. Complex cases take longer for doctors diagnose or treat, which can create challenges in keeping to appointment schedules and/or being able to give patients with complex needs adequate time. Doctors may also need to co-ordinate with multiple other services or colleagues to manage the patient's care

effectively, and/or may need to consult more senior or specialist doctors to ensure good decision-making.

Doctors described a range of situations that resulted in this increasing complexity, which were often interlinked. These included:

- Long waiting lists for secondary care and/or challenges reliably accessing primary care meaning that patients' conditions were more advanced when first seen or treated;
- Due to medical advances, patients living longer with chronic conditions, or being treated when they previously would have been on palliative care;
- Population trends that doctors feel have resulted in a less-healthy population, included increasing obesity rates, people getting cancer at younger ages, and an ageing population (with people living longer, but not necessarily in good health);
- Patients presenting in medical settings with non-medical concerns (such as housing, loneliness, or benefits issues, due to difficulty accessing other services or lack of understanding about GPs' role.

For GPs, long waiting lists and difficulty accessing primary care appointments sometimes led to patients presenting with **multiple concerns in a single appointment**. This requires extra time from doctors to assess patients and develop a treatment plan. Doctors may not have this extra time available, so are left with the option to either not give the complex patient sufficient time or overrun an appointment to fully deal with their issue, but risk knock-on consequences for other patients in the following appointments. GPs must then make rapid decisions about which concerns to address in that appointment, and which can be left, but, even then, risk overrunning.

Additionally, some feel the proportion of cases doctors see that are more complex has increased in part because simpler cases are now sometimes directed to other healthcare professionals, such as advanced nurse practitioners or pharmacists.

Complex and/or rigid systems

When prompted about barriers relating to the complexity of system processes, doctors mentioned that **confusing administrative systems and processes** contributed to some difficulties providing a sufficient level of care. Doctors described having to invest significant time and energy into working out how to complete administrative tasks or navigate local processes, especially doctors in training or international medical graduates who have recently arrived in the UK. For example, a lack of clarity about the process for making a certain referral sometimes led to doctors having to call many different people before finding the right person to send a referral to, or having to re-send a form multiple times due to processes frequently changing and these changes not being communicated.

> *"They change the way they do things quite frequently and do not communicate that, so the way we communicated a year ago has changed but they haven't told us. We call the person we have always called, just to be told that is not what you do anymore, but there is no clarity in what you do [instead]. I had one patient who died whilst we made multiple phone calls with somebody telling us it was somebody else's job, and they gave a number which we had called, and they had told us to ring you. By the time we had made all those calls, the patient was no longer alive"*
>
> **SAS doctor, Secondary care**

Some doctors in secondary care reported that confusion sometimes led to inappropriate referrals, such as patients who did not meet the eligibility criteria for a service. This wasted time (both for doctors and patients) and could lead to delays in accessing the appropriate service.

In some instances, processes or system did not allow doctors to do what they felt they needed to do to provide sufficient care. For example, doctors in A&E reported **not being allowed to address incidental issues**, or **restrictions on who can make a specific type of referral** (e.g. outpatient referrals). This led to some doctors feeling frustrated or even upset about not being able to give the care a patient needed, especially if they feel the patient may not have access to that care elsewhere, as well as wasted time when a patient then has to wait for care in a different setting.

> *"[For non-emergency issues] I have to say, 'go to your GP and ask them to refer you'… Why am I passing it around? Why can't I do it myself?... There's a layer of delay for the patient accessing something they need… You see people three weeks later and they still have not been referred, and it is like, 'I am sorry'."*
>
> **Locally employed doctor, Secondary care**

More positively, some doctors reported good experiences with management teams who they felt were willing to show flexibility when setting up systems or processes, were realistic about what could be achieved, and listened to doctors' feedback. Examples included a triage system being introduced to identify patients who may need more time than a standard appointment, and a cap on the number of patients seen per day being introduced after doctors raised concerns about workload intensity.

Supportive colleagues

Doctors cited **positive working relationships** and/or a **supportive team** as an important enabler to providing sufficient care.

Some doctors felt that **being part of a collaborative team could mitigate the impact of high workloads** on their ability to provide a sufficient level of care. Working and communicating well as a team, for example by supporting a colleague to complete a procedure they were struggling with, was felt to be more efficient, especially where doctors had good relationships with other healthcare professionals (e.g. nurses) or services. Having skilled, reliable and committed colleagues also meant work was spread fairly across the team, reducing the risk of more extreme workload pressures on any individuals.

Having **supportive and available senior colleagues** was very important to early career doctors in feeling confident providing sufficient care. When early career doctors (including both doctors in training and LE doctors) could **easily access advice and guidance**, they felt better able to provide effective care in complex cases. Conversely, when they felt they had been left without sufficient supervision of their work by senior doctors, they felt less confident in their ability to make good decisions in more challenging situations. They consequently worried about **potential risks to patient safety** if they encountered a situation where they did not have the expertise to provide sufficient care. This aligns with findings from the Barometer survey, where almost a fifth (19%) of all doctors and a third (33%) of doctors aged under 30 cited 'insufficient support from senior colleagues' as one of the main barriers to good patient care

> *"In my workplace you're encourage to, if you're not sure, just ask someone, whether that's your colleague or your senior, so you don't feel alone in that challenging*

situation… My senior colleagues, the consultants, they are always available, always reachable to help you sort out any tricky situations."

Locally employed doctor, Secondary care

The supportiveness of senior colleagues also impacted how confident early career doctors felt about **raising concerns** about patient care. Unsympathetic responses from senior colleagues when early career doctors raised concerns had a strong emotional impact, leaving doctors in training feeling isolated, frustrated, and scared to speak up in future if they had similar concerns. Supportive responses helped them to feel more confident discussing things they were finding challenging or raising patient safety concerns.

Some felt the supportiveness of colleagues was connected to workload pressures, as they felt their colleagues were less willing to offer support when under pressure themselves.

Inadequate material resources or physical infrastructure

Challenges accessing necessary material resources or appropriate rooms in buildings sometimes caused doctors difficulty in providing patients with sufficient care, especially in secondary care settings.

A **lack of reliable access to basic equipment** such as needles, hoists for disabled patients or ECG machines sometimes resulted in delays to treatment or being unable to provide ideal care. Findings from the Barometer Survey suggest this is an issue for a sizeable minority of doctors, with over 2 in 5 (42%) of doctors saying that a lack of access to necessary equipment or services was one of the main barriers to providing good patient care.

Some doctors reported poor infrastructure caused or exacerbated delays to care, reflecting in the 39% of doctors who cited inadequate physical infrastructure in the Barometer Survey. Some interviewees reported not being able to carry out appointments or procedures because of **a lack of available consultation rooms or operating theatres,** either due to insufficient capacity in the building, or due to **disrepair meaning rooms or theatres were repeatedly out of use.** Some reported that **inappropriate or poorly designed buildings** interfered with their ability to provide good care easily, for example where rooms are too small or lack privacy. In some cases the building lacked the facilities necessary to provide certain types of care that would otherwise be expected, such as being unable to manage leg ulcers due to a lack of permanent dressing stations in a converted office building.

A few doctors sometimes experienced difficulty getting patients **access to medications** they need due to cost or availability, including medications that could prolong their lives.

"Oftentimes I spend my time running around trying to find a needle to take bloods, and I go to three different wards."

Locally employed doctor, Secondary care

Access to interpretation services was sometimes challenging, leaving doctors unable to communicate with patients. For scheduled appointments, some doctors found the administrative process for arranging an interpreter to be long and time-consuming, needing booking far in advance. In acute or emergency settings, some doctors said they were regularly **unable to access unscheduled interpretation services** or had to wait a very long time. This could lead to

misdiagnosis or suboptimal treatment due to the inability to communicate, as well causing distress to patients.

Even when doctors were able to access an interpreter, some felt the quality of the interpretation was poor, or the interpreter not appropriate, for example a male interpreter without the vocabulary to discuss gynaecological concerns.

> *"Sometimes I notice that what the patient is saying might not really be what the interpreter is saying… I'm looking at the patient's face and wondering, 'Is this really what this gentleman wants to communicate to me?'."*
>
> **GP in training, Primary care**

5. Reported impacts of difficulty providing a sufficient level of care

This chapter discusses the interviewed doctors' experiences and perceptions of the **effects** and **impacts** of finding it difficult to provide a sufficient level of care – on themselves, on their relationships with colleagues, and on patients. Effects, in this context, describe short-term, in-the-moment consequences doctors experience while providing care, while impacts are the longer-term or cumulative consequences.

Effect and impact on individual doctors of difficulties providing a sufficient level of care

Doctors described experiencing **substantial and multiple personal impacts** from difficulties providing sufficient care. While there are some moments of fulfilment and professional growth, the dominant experience described is one of emotional and physical demands, moral discomfort, and uncertainty about long-term sustainability. These shows the importance of addressing the systemic conditions that affect doctors' ability to deliver care and support the retention of the medical workforce.

Negative effects on doctors

Doctors described significant emotional strain associated with the daily experiences of finding it difficult to provide sufficient care. Feelings of frustration, guilt and emotional strain in relation to uncertainty about whether patients were receiving the right level of care were frequently felt. In daily practice, these were often exacerbated by administrative burden, the need to advocate for patients within constrained systems, and the challenges of managing patients with complex mental health needs or distressing behaviours.

Doctors often fitted in extra patients and supported colleagues, frequently skipping breaks to manage rising demand and maintain service continuity. Accommodating additional patients and allowing more time for complex needs could result in clinics running late, leaving doctors open to criticism from managers or patients for overrunning scheduled slots. Participants described feeling torn between providing thorough, patient-centred care and meeting rigid time targets, with some noting that unrealistic expectations – such as completing complex consultations in 10-15 minutes – forced them to rush and compromise on quality. Others highlighted that staying late to finish documentation or accommodating extra patients often led to fatigue and stress, while still being perceived as inefficiency rather than commitment to quality care.

Alongside emotional impacts, some doctors described the effect this was having **on their physical health.** This included persistent tiredness and feeling drained at the end of the day. Feelings of worry and guilt were also prominent, particularly in relation to uncertainty about whether patients were receiving the right level of care Some doctors described taking these concerns home with them, replaying cases mentally and questioning clinical decisions after hours. This difficulty in switching off directly affected sleep and rest, creating a cycle of fatigue that carried into subsequent working days.

"Whenever you go home, [you think] 'what about that lady? Maybe I should have been able to do this or that, I hope they are okay.' I am now planning how to emigrate to get away from this."

Locally employed doctor, Secondary care

Resulting impacts

These effects were described as cumulative, rather than episodic, contributing to longer-term impacts. Sustained inability to provide the level of care they perceived as sufficient led many to describe **burnout**, **diminishing job satisfaction**, and a growing **sense of moral discomfort**. These decisions were not driven by a lack of commitment to patient care, but by sustained exposure to very specific pressures that doctors felt prevented them from thriving professionally and deliver patient care to their own standards: unmanageable patient volumes; chronic staffing shortages; prolonged referral delays; growing administrative workloads; fragmentation between services.

"You come into this job because you want to be able to make a difference, and the futility of hitting your head against a brick wall every day is so demoralising."

Locally employed doctor, Secondary care

Several doctors reflected on how repeated experiences of not being able to provide the care they would like had begun to **erode their professional identity**. They described feeling less empathetic, less fulfilled, or increasingly disconnected from the values that originally motivated them to practise medicine. Some expressed concern that they were becoming more negative or cynical in response to relentless pressures.

"I like what I do but I hate the system. I hate the lack of time, and the automatization. But I like my occupation and I like my patients. [The practice managers] bombard you with tasks, and they don't realise that the impersonal passing on of tasks without seeing the person is causing distress at work."

Salaried GP, Primary Care

A small number also reported **worry about long-term health consequences**. **Persistent fatigue and high stress levels** had caused some doctors or their colleagues to have increased sickness absence. Some of these doctors expressed concern that prolonged stress could lead to serious health consequences, such as cardiovascular events, highlighting the extent to which work-related pressures were perceived as threatening not only professional wellbeing but personal health.

"We get frustrated on a daily basis most definitely and tired and don't want to work as much to be honest and one of the reasons we are at a high risk of burnout."

GP Partner, Primary Care

For many doctors, these cumulative impacts prompted reflection on their future within the profession. Participants spoke about considering leaving medicine altogether, moving to practise abroad, transitioning into private practice, reducing their working hours, or taking early retirement. For some, the emotional burden of feeling unable to do "enough" for patients contributed to a growing desire to distance themselves from the current healthcare environment altogether.

These considerations were often framed not as a lack of commitment to patient care, but as a response to working in systems that doctors felt no longer enabled them to thrive professionally or deliver care to their own standards. As one GP reflected, prolonged exposure to these pressures had led them to feel increasingly disengaged and pessimistic about their role, noting a sense of personal change towards bitterness and dissatisfaction.

> *"I was very close to burnout … I recognise when I am not in a healthy organisation and not in a system where I can thrive and feel empowered … I feel I have changed [since practicing in the UK] and becoming a little bit more bitter, negative and complaining."*
>
> **Specialist, Secondary Care**

Positive and sustaining effects

Despite the challenges, doctors also identified factors that continued to provide fulfilment and motivation. Professionals in both primary and secondary care described moments of success, such as achieving positive patient outcomes, being able to follow up with patients, or delivering timely and effective treatment, as sources of personal satisfaction. These experiences were seen as affirming the value of their work and reinforcing their commitment to patient care, even in demanding circumstances.

> *"But being a GP is a great job… despite the frustrations and the demands, I get a lot of satisfaction from my job. Overall, it's quite rewarding when you can help patients and advocate on their behalf… and deal holistically."*
>
> **Salaried GP, Primary care**

Maintaining clinical integrity, adhering to guidelines and advocating for patients where possible were described as important ways of **preserving a sense of professional identity and self-respect**. In some cases, participants framed ongoing challenges as opportunities for professional development. One secondary care doctor highlighted that constraints motivated them to engage more deeply with clinical guidance and pursue independent learning, using these pressures to strengthen their knowledge and skills outside formal training structures.

> *"The positive side is, if you become frustrated [with no senior support] you can look at the guidelines and protocols to see what they say so has a positive side in you wanting to study that to help the patient."*
>
> **Doctor in training, Secondary care**

Effect and impact on doctors' relationships with their colleagues due to difficulties providing a sufficient level of care

Some doctors associated difficulties providing a sufficient level of care with **increased tension in their professional relationships**, particularly when time or resources are under strain. However, most doctors were still able to maintain positive working relationships with their colleagues.

Negative effects on doctors' relationships with colleagues

Doctors described a range of immediate effects on their day-to-day interactions with colleagues when they were experiencing difficulties providing sufficient care. These effects usually occurred when difficulties providing care stemmed from inadequate staffing, resources or service capacity, doctors said conflict could arise between colleagues when they have to negotiate with their colleagues to try to secure the right care for their patients.

For example, when a doctor needs to **pass a patient's care onto another team or service** (e.g. making a referral or admitting a patient from A&E), they may be initially told that that team or service lacks the capacity to take the patient on (e.g. due to no available beds, or lack of staff capacity). Doctors are then left to negotiate with their colleagues to try to get their patient the care they need, either from the initial department or from an alternative source, which can lead to **friction in their relationships if this negotiation becomes a 'battle'**. Some doctors recalled instances when this pressure led to colleagues acting inconsiderately during this process. A few recalled departments attempting to reduce their workload by passing patients on to other teams or settings, who may themselves also be struggling.

> *"You do sometimes feel we are pitched against each other in a way. The profession is a lot more divided than it used to be… you might have a ward doctor that has no beds to put a patient in and a GP saying I have a patient that needs to be in hospital and a little battle going on… It is difficult with colleagues and putting relationships under strain – that game of tennis."*
>
> **GP Partner, Primary care**

Doctors working in **primary or emergency care**, who frequently need to transfer responsibility for patients, **felt particularly affected** by this issue. Some doctors working in primary or emergency care felt **undermined or unappreciated** because they felt their colleagues disregarded their clinical decisions about whether to refer or admit patients. They believed their colleagues only did this in order to reduce the number of patients they were responsible for, e.g. a colleague working on a ward requesting that a patient is assessed again or tests unnecessarily re-run after an A&E doctor asks for the patient to be admitted to the ward, in the hope that they can avoid or delay admitting them.

> *"Because of the volume, the capacity, and how much everything is overwhelmed, the decision [in A&E] to admit is almost laughed at by people… [other departments will say], 'how do you know it's not this? Have you done this?' … But the reason that person comes back to me like that is because they're looking at how many patients have been referred to them, and the answer is too many… People are kicking the can down the road until they absolutely have to deal with it."*
>
> **Locally employed doctor, Secondary care**

Some doctors described **friction with staff in other roles**, due to a sense they were not effectively working towards the same goal. These situations were described as immediate sources of tension or frustration at the point of care.

Wider impacts on doctors' relationships with colleagues

Difficulties providing sufficient care also had **wider, cumulative impacts on team relationships and the broader working culture**. A few doctors recalled **unhelpful and/or unproductive reactions**

from colleagues after an issue relating to providing sufficient care had arisen. This includes senior staff not supporting early career colleagues, or reviews of specific cases being conducted by staff who they felt were not sufficiently qualified to provide a judgement.

> *"I think there's a lot of resentment and blame and intolerance of incompetence. So, you know, seniors are frustrated with us because we can't do what they hope that we could do and that adds to their workload and vice versa."*
>
> **Locally employed doctor, Secondary care**

Some felt **clinical and/or non-clinical leadership were not supportive** when issues were raised relating to difficulties providing sufficient care, such as staffing levels or workloads that they felt were unsafe. Typically this was due to a sense that managers did not listen to or adequately act on these concerns, but some doctors were worried about negative consequences if they spoke up, causing them to decide not to raise their concerns. In other cases, doctors felt management teams were overly focused on cost-cutting measures and did not consider the impact of their policies on patient care or safety.

> *"As a consultant, there's nobody to talk to about [concerns] …It falls back to you because they punish you …You're always under stress because of it, which affects your state of health and that affects patient care."*
>
> **Specialist, Secondary Care**

> *"I have lots of [corncerns] to raise, but I don't know what's going to happen… I'm afraid if I raise it to the programme director he will give me a bad review – which happened to other colleagues – or he would just refuse to give a review, which also happened with other colleagues in his programme. So I don't feel safe in any way to raise concerns."*
>
> **Doctor in training, Secondary care**

Positive and sustaining effects

Despite this, many doctors interviewed felt that they were **still able to maintain overall positive working relationships** in the face of these challenges, or that difficulties providing a sufficient level of care had no impact on these relationships at all. They describe having empathy for colleagues' struggles and understanding that challenging situations were usually not their colleagues' fault. This reflects findings from the Barometer survey that indicate most doctors have positive relationships with their colleagues, including 82% of doctors saying they felt supported by their immediate colleagues, and 71% that they felt they were part of a supportive team.

> *"I don't think it affected relationships with colleagues so much – we are all in the same pot of soup, shall we say."*
>
> **Salaried GP, Primary care**

Some doctors mentioned **some positive impacts** on their working relationships in the face of challenges providing sufficient patient care, though they typically also reported other negative impacts alongside these. Some doctors described how discussing stressful experiences with colleagues could **build camaraderie** or empathy and encourage team working, as long as pressure levels were still within manageable limits. A couple of doctors reported that challenging situations involving difficulty providing sufficient care had **sparked discussions** among

their colleagues of how to make improvements, but with mixed expectations as to whether they would actually be able to drive change.

> *"We do discuss how things could be better or improved. But because we don't have any administrative power, what we can change in a Trust is quite limited, especially around senior support on the ward, which has not been fantastic."*
>
> **Doctor in training, Primary care**

Effect and impact on patients of difficulties providing a sufficient level of care

Doctors interviewed felt that it was **very rare for immediate patient safety to be affected** by their reported difficulties providing a sufficient level of care. However, they still felt that patients experienced negative impacts nonetheless, particularly due to conditions **deteriorating as a result of delays** and patients **feeling scared, upset or overlooked**.

Negative effects on patients

As outlined earlier in the report, most doctors interviewed perceived it to be **very rare for patients' safety to be impacted** by difficulties providing sufficient care. They felt that the healthcare system had sufficient 'guardrails' or 'backstops' to ensure than safety risks would be caught before patient safety was actually compromised.

> *"To be honest, and I want to be clear about this, it's never about patient safety. Patient safety is always a priority, and I can only remember a very, very few number of patients where I did feel there was a problem with safety."*
>
> **Doctor in training, Primary care**

However, doctors felt that difficulties providing sufficient care could have a **negative emotional impact on patients**, even when their physical health was not significantly affected. Doctors often encountered patients who were **in pain, distressed, or dissatisfied with their care**. In particular, doctors reported that patients could feel **frustrated or upset** by long waiting times and/or poor communication from services, which sometimes meant patients were left worried or in pain for long periods. Some patients **did not feel listened to** because short appointment times and a lack of continuity of care reduced doctors' ability to build a personal connection.

> *"It makes them distressed, anxious and worried… often they [become] frightened and wary of engaging with healthcare because they feel they have been let down."*
>
> **SAS doctor, Secondary care**

> *"I am ending the consultation with giving them advice on how to monitor themselves and caveating with this is what you need but I can't arrange that from this environment, and you can see them feeling crestfallen and it sucks my soul away from me."*
>
> **Locally employed doctor, Secondary Care**

These negative experiences were felt to **undermine doctors' relationships with their patients**, especially in primary care. GPs felt some patients considered **them to be responsible for the wider systemic issues in the NHS** (as outlined in the previous chapter), because GPs are the 'face' of the system for many patients, even when an issue is not in a GP's control.

> *"[Patients] just lose heart in you because you are sitting in front of them as the face of the NHS and patients are so angry… When people come in here there is a sense they will have to fight for anything, which changes the whole mood of the*

interaction. [The relationship] is poor, and patients don't have any faith that you are going to give them the care they need – which is true. There's a sense that you are useless, not working hard enough and you don't really care."

Salaried GP, Primary care

Wider impacts on patient experience

Doctors identified that in some cases difficulties providing sufficient care **did result in negative impacts on patients' health**, mostly due to patients' conditions **getting worse during long waits**. This was thought to particularly impact patients with complex conditions, as they were thought to be more likely to experience gaps in their care, and may not receive whole-patient care when they are being seen by a number of different services.

Some doctors reported that negative experiences of accessing care had **impacted their patients' decisions about whether or how to seek care on subsequent occasions.** GPs described how some of their patients who had had poor experiences with emergency or primary care (or who had heard of others' poor experiences) were subsequently reluctant to seek help again if they had a new or recurring medical issue, potentially resulting in risks to their safety. Some doctors in both primary and secondary care described how patients who remained in pain or had not had their concerns sufficiently addressed sometimes presented multiple times or at multiple settings in an effort to access the care or support they had expected but not received, especially while on long waiting lists for specialist care.

"If you don't deal with a patient's initial concerns well enough, then they're going to have to seek healthcare attention again and again elsewhere… On both the patient side as well as the health system side, [insufficient care] just creates more work in the long run."

Doctor in training, Secondary care

Positive and sustaining effects

Despite the potential negative impacts on the doctor-patient relationship, most doctors **still felt they could maintain good relationships with their patients**. This aligns with the Barometer survey results where 88% of doctors agreed they had positive patient relationships. Interviewees said many of their patients recognised that any difficulties providing sufficient care were often not the fault of the individual doctor who cared for them. As long as challenges providing care were **communicated clearly and openly,** doctors reported that patients could be **forgiving of delays,** and v**ery grateful** for the care doctors still were able to give them in the face of those difficulties. Positive experiences of doctors putting in effort to overcome difficulties to secure care for their patient sometimes strengthened doctor-patient relationships.

6. Key findings

Findings in this report draw on in-depth interviews with a small but diverse sample of 40 doctors to explore understanding of what "difficulty providing a sufficient level of care" looks like in practice, the pressures that drive it, and the conditions that help mitigate it. While these qualitative findings are not statistically generalisable and reflect a limited number of participants, they offer depth, nuance and rich insight into doctors' experience. Furthermore, clear patterns emerged across settings and career stages, offering insight into how the wider system context shapes doctors' day-to-day ability to meet the standard of care they aspire to.

Doctors defined sufficient care by timeliness, whole-patient support and patient-centredness. They described "sufficient" care as delivering interventions within appropriate clinical timeframes, addressing emotional and social needs alongside clinical ones, and listening and tailoring care to individual circumstances. Further to professional standards and guidance, doctors often benchmarked levels of care against personal standards such as the 'friends and family test', aiming to deliver care they would want for their own loved ones.

'Difficulty providing sufficient care' rarely implied compromised safety; it reflected falling short of personal standards under sustained pressure. Doctors consistently described a working environment defined by high workload intensity, inadequate staffing, increasing administrative demands, and complex or rigid organisational systems. These pressures work together to restrict the time and flexibility doctors have to provide the kind of timely, holistic and patient-centred care they associate with "sufficient care." In many cases, this meant consultations become focused on the most immediate clinical needs, with less scope for broader discussion, continuity, or preventive approaches. Difficulty accessing onward services, long waiting lists, and delays in referrals further compound these challenges, often resulting in patients returning with unresolved or worsened symptoms. This created a cycle of repeated presentations that places additional pressure on services.

Doctors explained how **finding it 'difficult' to provide a sufficient level of care also related to emotional strain** of trying to overcome these systemic barriers and the frequent feeling of not being able to deliver the level of care they aspire to or *should* be able to (if the challenges were removed).

Doctors working in primary care were more likely to emphasise continuity and whole-patient support when defining a sufficient level of care and identified autonomy as the most significant enabler. GPs described difficultly providing patient care due to short consultations, fragmented care pathways and lower control. **Those in secondary care focused on technical standards and timely interventions** when determining what constituted a sufficient level of care. They cited effective multidisciplinary coordination, established support, and clearer protocols as enablers to providing sufficient care, but faced acute resource constraints (such as theatres, specialist staff, and scans).

Doctors earlier in their careers reported **less autonomy, greater reliance on senior support, and more difficulty navigating complex systems**, all of which made it harder for them to deliver the standard of patient care they aspired to. More experienced doctors generally had **greater control over their workload and decision-making**, enabling them to mitigate some pressures, though they were more affected by **system-wide constraints** such as lack of resources and delays to patient care.

Frequently being unable to provide a sufficient level of care, and the experience of barriers preventing this, had **substantial and cumulative impacts on doctors, and there is a resulting risk of**

doctors taking steps to leave the UK medical practice. This includes moving abroad, early retirement, private practice, or leaving medicine altogether to protect their wellbeing.

Doctors felt that impacts on patients centred on experience and continuity rather than immediate safety. Long waiting lists, repeated presentations, and limited time for discussion which addressed wider and contextual factors/issues drove frustration and anxiety, eroded trust in the healthcare sector and doctors, and sometimes worsened conditions during delays (placing further pressure on services). Clear communication and compassionate moments was felt to help mitigate these impacts, and enabled doctors to sustain positive relationships.

Addressing workload drivers (staffing, administrative efficiency), improving IT interoperability across settings, strengthening senior support and psychological safety, and enabling clinician-led service models and autonomy are felt by doctors to be central to maintaining care standards, safeguarding wellbeing, and supporting retention.

Appendix: Topic Guide

Introduction

1. **To start off, could you tell me a bit about your role, and the setting you work in?**
   A) Roughly what proportion of your overall working hours do you spend directly delivering patient care?
   B) What is the balance with other aspects of your role - admin work, providing supervision or training, management, and providing support to other staff members.
2. **What is your current working pattern?**
   A) Do you work on a full-time or part-time basis?
   B) And, on average, how much work (if any) do you do beyond your rostered hours on a weekly basis?
3. **Do you occupy any other positions, or have any other responsibilities outside of the role we have just discussed?**

Key questions (c. 35 mins)

Defining 'a sufficient level of patient care'

The SoMEP Barometer survey 2024 found that two-fifths (40%) of doctors stated that they found it difficult to provide a patient with the sufficient level of care they need on at least a weekly basis. This was a key finding, but we recognise that there will be variation in how doctors define a 'sufficient level of care'.

The next few questions explore how different doctors interpreted this statement, and what it means, in practice, to them in their role. We are not trying to check-up on an individual doctors' behaviour but rather gain a deeper understanding of this finding across a range of doctors (regardless of how they responded to this survey question).

4. **What does 'providing a patient with a sufficient level of care they need' mean to you?**
   A) How do you judge whether you have been able to provide sufficient levels of care on a given day/session? Or For an individual patient consultation and/or case?
5. **What does 'finding it difficult' to provide a patient with a sufficient level of care mean to you?**
   A) Are you able to describe what finding it difficult looks like in practice?
   B) What does this look like in your role?
   C) How often do you find it difficult to provide a patient with a sufficient level of care?

Factors enabling and preventing doctors from providing patients with a sufficient level of care

We are also keen to understand what factors tend to influence whether a doctor feels able (or unable) to provide a sufficient level of care.

6. **What factors do you feel most frequently influence (positively or negatively) your ability to provide patients with a sufficient level of care?**

   PROMPT IF NECESSARY: This could include workload and time constraints, the physical environment you work in, system complexity, patient factors, organisational factors etc.

   FOR EACH FACTOR MENTIONED, MAKE SURE YOU UNDERSTAND IF IT IS AN ENABLER OR BARRIER, AND USE PROBES:

   A) How does this factor affect the care you are able to provide?

   B) How often does this happen?

   IF NOT ALREADY MENTIONED AS A FACTOR:

   A) How does the intensity of daily clinical work impact the patient care you are able to provide?

      PROMPT IF NECESSARY: This could be intensity arising from a range of sources, such as your workload, patient expectations and system-demands, IT/accessing records information required.

   B) How does the complexity of patient needs impact the patient care you are able to provide?

      PROMPT IF NECESSARY: This could include reflecting on the patient/condition aspect of complexity (i.e. multi-morbidities or complex cases)

   C) How does the complexity of organisation processes impact the patient care you are able to provide?

      PROMPT IF NECESSARY: This could include complexity within healthcare system processes (e.g. referrals, use of technology). If technology mentioned, please ask for specifics – e.g. is it technology that supports with administrative work, diagnostics, treatment, etc.

7. *IF TIME:* **Is there anything we haven't already discussed which you feel often makes it difficult for you to provide patients with a sufficient level of care?**
8. **Is there anything we haven't already discussed which you feel often enables you to provide patients with a sufficient level of care?**

   A) Is there anything you feel could be changed to better enable you to provide patient care?

NOTE TO INTERVIEWER: IF RESPONDENT LISTS OFF A LOT OF FACTORS, GET THEM TO FOCUS ON THREE (DEPENDING ON TIME, COULD BE FEWER COULD BE DRIVEN BY THE TOP 3 CHALLENGES) THEY THINK WOULD HAVE THE BIGGEST IMPACT ON THE MAIN CHALLENGES PREVIOUSLY CITED.

Effects of being able / unable to provide sufficient care on a frequent basis

For the final few questions, I'd like to explore the impact of being able or unable to provide patients with a sufficient care has on you, your patients and your interactions and relationships within the healthcare system.

INTERVIEWER NOTE: Throughout this section, ensure that you are exploring the positive and negative aspects of being able/unable to provide sufficient patient care.

9. **Firstly, how is the patient experience affected when you find it difficult to provide patients with a sufficient level of care?**

   ALLOW SPONTANEOUS RESPONSE THEN PROBE FOR IMPACTS ON:

   i) Managing patient expectations

   ii) The referrals process and continuity of care for patients

   A) In what ways, if at all, does this influence the patient-doctor relationship?

   B) And what are the positive impacts of being able to provide sufficient levels of care **for patients?**

10. **And what is the effect on you if/when you find it difficult to provide a sufficient level of patient care?**

    ALLOW SPONTANEOUS RESPONSE THEN PROBE FOR IMPACTS ON:

    i) Ability to uphold professional standards

    ii) Job satisfaction

    iii) Personal well-being

    iv) Career progression

    v) Feelings towards being a doctor

    B) And what are the positive impacts of frequently / always being able to provide sufficient levels of care for **you?**

11. **How do difficulties in providing a sufficient level of patient care affect your relationships with colleagues?**

    A) How does it shape your relationship with other parts of the healthcare system?

Closing questions (2 minutes)

12. **Is there anything else you would like to add to our conversation today?**

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1. Being human first

Whether employer or employee, client or collaborator, we are all humans first and foremost. Recognising this essential humanity is central to how we conduct our business, and how we lead our lives. We respect and accommodate each individual's way of thinking, working and communicating, mindful of the fact that each has their own story and means of telling it.

2. Impartiality and independence

IFF is a research-led organisation which believes in letting the evidence do the talking. We don't undertake projects with a preconception of what "the answer" is, and we don't hide from the truths that research reveals. We are independent, in the research we conduct, of political flavour or dogma. We are open-minded, imaginative and intellectually rigorous.

3. Making a difference

We aim to make a difference to the lives of our partners, our people and wider society, through the research we do and the way we work. We're proud to work with partners who share our ambition for positive change, and choose to work on projects that can make a positive impact.

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